Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ABBAS MIAN MD
3100 TIMMONS LANE SUITE 250
HOUSTON TX 77027

Carrier's Austin Representative Box
Box Number 19

Respondent Name
NEW HAMPSHIRE INSURANCE CO

MFDR Date Received
January 20, 2012

MFDR Tracking Number
M4-12-1687-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "CARRIER REFUSES TO PAY FULL AMOUNT DUE FOR SERVICES RENDERED EVEN AFTER A REQUEST FOR RECONSIDERATION WAS SUBMITTED."

Amount in Dispute: $150.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The medical bill(s) made the basis of this Medical Fee Dispute have been sent back the bill audit vendor for an additional review along with the information provided by the Requestor."

Response Submitted by: Pappas & Suchma, PC, P.O. Box 66655, Austin, TX 78766

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
February 18, 2011	CPT Code 99456-W5-WP	$150.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

The Division contacted the requestor's representative, Glynnis Singleton via telephone on March 20, 2012, to confirm the status of dispute. Per requestor's representative, Glynnis Singleton, no additional payment has been received from the respondent.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.

2. 28 Texas Administrative Code §134.204 sets out the fee guidelines for the reimbursement of workers'

compensation specific codes, services and programs provided on or after March 1, 2008.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated March 24, 2011
   - W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - 21 – (217) BASED ON PAYER REASONABLE AND CUSTOMARY FEES. NO MAXIMUM ALLOWED DEFINED BY LEGISLATED FEE ARRANGEMENT.
   - BL – TO AVOID DUPLICATE BILL DENIAL FOR ALL RECON/ADJUSTMENTS/ADDITIONAL PYMNT REQUESTS, SUBMIT A COPY OF THIS EOR OR CLEAR NOTATION THAT A REC

   Explanation of benefits dated July 20, 2011
   - W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.

   Explanation of benefits dated November 2, 2011
   - W1 – (W1) WORKERS COMPENSATION STATE FEE SCHEDULE ADJUSTMENT.
   - BL – THIS BILL IS A RECONSIDERATION OF A PREVIOUSLY REVIEWED BILL, ALLOWANCE AMOUNTS DO NOT REFLECT PREVIOUS PAYMENTS.

Issues

1. Were the services in dispute appropriately billed?
2. Has the Designated Doctor (DD) examination been reimbursed appropriately per 28 Texas Administrative Code §134.204?
3. Is the requestor entitled to additional reimbursement for the disputed services under 28 Texas Administrative Code §134.204?

Findings

1. The requestor billed the amount of $1,100.00 for CPT code 99456-W5-WP with 4 (four) units in Box 24G of the CMS-1500. The Division order on the EES14 and DWC032 was to determine Maximum Medical Improvement/Impairment Rating (MMI/IR) and the ability of the employee to return to work. The Division ordered the Designated Doctor to rate the back and neck, hand and upper extremities and lower extremities and feet.

   28 Texas Administrative Code §134.204(j)(4)(C) states, "For musculoskeletal body areas, the examining doctor may bill for a maximum of three body areas.

   (i) Musculoskeletal body areas are defined as follows:

   (I) spine and pelvis;

   (II) upper extremities and hands; and

   (III) lower extremities including feet).

2. Review of the submitted documentation supports that Maximum Medical Improvement (MMI) was assigned and per 28 Texas Administrative Code §134.204(j)(3)(C), the Maximum Allowable Reimbursement (MAR) for MMI is $350.00. Review of the documentation supports that MMI was assigned and 3 body areas were rated, the cervical/thoracic spine (spine); shoulders/elbows (upper extremities) and hips/ankles (lower extremities). To determine reimbursement for an IR, the method of calculating IR and the number of body areas/conditions are reviewed. The Impairment Rating per AMA Guides to the Evaluation of Permanent Impairment, 4th Edition for the MAR per 28 Texas Administrative Code §134.204 (j)(4)(C)(ii)(II)(a) for the 1st musculoskeletal area using Range of Motion method on the compensable cervical/thoracic spine (spinal) is $300.00; the 2nd musculoskeletal area per 28 Texas Administrative Code §134.204 (j)(4)(C)(ii)(II)(b) on the shoulders/elbows (upper extremities) is $150.00 and the 3rd musculoskeletal area per 28 Texas Administrative Code §134.204 (j)(4)(C)(ii)(II)(b) on the hips/ankles (lower extremities) is $150.00. The combined Maximum Allowable Reimbursement (MAR) for the disputed CPT code 99456-W5-WP is $950.00. Since there are only 3 musculoskeletal areas rather than 4, and 3 areas were rated, the combined MAR for the MMI and 3 units for the IR areas is $950.00.

3. The respondent has previously reimbursed the requestor the amount of $950.00 for the disputed CPT code 99456-W5-WP. Therefore, the requestor is not entitled to additional reimbursement.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	July 16, 2012 Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute may appeal this decision by requesting a contested case hearing. A completed **Request for a Medical Contested Case Hearing** (form **DWC045A**) must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.